

PUBLIC HEALTH REPORT

Louis F. Saylor, M.D., M.P.H., Director, State Department of Public Health

Suicide Prevention — The Physician's Role

DO PHYSICIANS FAIL to recognize significant clues to suicide? If so, this would account for failure to forestall preventable deaths.

Suicide has been among the ten leading causes of death in California since 1910.¹ In 1968, it accounted for 3,427 deaths.² Unsuccessful attempts are sometimes estimated at seven to eight times the number of completed suicides and many who try once and survive, kill themselves later.

California's 1968 suicides ranged in age from under 20 to over 80, with 1,069 between the ages of 40 and 55. Particularly high rates are found in all age groups over 40. The major means were firearms and explosives, followed by drugs, including barbiturates and sleeping pills. Other agents and methods were poisons, gas, carbon monoxide, hanging, strangulation, drowning, cutting and piercing instruments, and jumping from high places.

Among the persons who kill themselves, often during the most productive years of their professional lives, are a significant number of physicians, and most commonly among them, psychiatrists. As early as 1903, the American medical profession noted its own high suicide rate.³ Studies in the United States and Great Britain attest the continuing vulnerability of physicians, especially those under 50. In both nations, easy access to drugs and development of drug dependence are cited as contributory factors.^{4,5}

Particularly poignant is the fact noted in one study that colleagues and wives of suicidal physicians desperately sought help from other physicians, friends and medical societies, but in vain. Yet physicians may be in a position to prevent such destructive acts.

The essence of prevention, according to a leading suicidologist, is in recognizing that the potential victim is "in balance" between his wishes to live and his wishes to die, and in throwing one's

efforts on the side of life.⁶ Most suicidal persons give notice of their intention by previous attempts, by direct or indirect verbal clues ("I'm going to end it all," "You'd be better off without me") or by such actions as putting affairs in order, giving away prized possessions or even buying a casket. Any such prodromal clue is a cry for help and should never be dismissed.

A particularly high risk group of potential suicides are persons over 40 with depression. Alcoholics, especially if they live alone, if they are about to lose or have recently lost a loved one, as by separation, divorce or death, are in special danger. Persons who suffer from anxiety, agitation, psychosis or organic impairment are at risk. So are patients who fear impending hospitalization, who are scheduled for surgical operation, especially mutilative, or who have learned that they may have or do have a malignant disease.

Adolescents are often at risk when the stresses of puberty and oncoming adulthood are too great for them. Some factors in the lives of male adolescents that are associated with suicide in later life have been identified in one study as loss of father through death or marital separation before son's entrance into college; the father's belonging to the professional class; cigarette smoking in college; failure to graduate from college; and self-assessed characteristics of insomnia, worries, self-consciousness and mood swings.⁷ Prolonged loss of sleep, ingestion of narcotics, sedatives, alcohol and hallucinogenic drugs may lead to loss of controls over self-destructive impulses.⁸

Undoubtedly, physicians succeed in preventing suicides, but they do have some failures. About half of all who kill themselves see a physician some time during the month before. On average, a physician sees six potentially suicidal patients each year, although rarely is the chief complaint as obvious as, "I'm thinking of killing myself."⁹

In one study of 175 consecutive suicides and 197 hospital admissions for attempted suicides in San Francisco, one of three killed himself with a drug available only on a physician's prescription and two out of five attempted to do so. The com-

plaints which brought the patients to the physician covered a wide range, but most often involved depression.¹⁰

Why do physicians sometimes fail to evaluate their patients' suicidal potential?

If physicians experience anxiety in dealing with suicide, it is difficult for them either to assess the patient's emotional state clearly or provide the emotional support the patient needs. A physician may fail to take preventive steps if his cultural attitudes toward suicide, professional pride and personal abhorrence make him deny to himself that this is imminent. And the greater the prestige of the patient, the more the physician may deny the possibility of suicide.¹¹

Yet the non-psychiatric physician is increasingly involved in identifying and managing depressed and suicidal persons. To reduce suicides, physicians should develop an active casefinding approach, a kind of awareness with a view to modifying depressed suicidal states before they become critical. Patients do not usually reveal spontaneously that they are thinking of suicide, but the physician's tactful questioning readily elicits this information, especially where there is a good patient-doctor relationship. The physician should, therefore, routinely inquire about depressive and suicidal states and, if appropriate, lead up gradually to questions about suicide plans. Further steps in management depend on the particular patient and the physician, but should include emergency medical and psychological support, consultation and referral when indicated and frequent communication with patients while they are still suicidal.^{12,13}

Sometimes physicians hesitate to talk of suicide to disturbed patients for fear of putting the idea into their minds. But in its experience the Suicide Prevention Center of Los Angeles has found no

evidence that such questions ever harmed patients.

Suicidology is a new and expanding field, linking medicine and the behavioral sciences. California has 25 percent of the nation's suicide prevention centers, including the outstanding Los Angeles center codirected by Norman Farberow, Ph.D. and Robert E. Litman, M.D., and staffed by a distinguished multidisciplinary team. This center carries out a broad program of evaluation, assessment, referral, training and research.

California's physicians may find it helpful to achieve good working relations with suicide prevention centers and other appropriate community service agencies, including police and fire departments and local poison centers.*

But perhaps the most important qualities a physician needs are sensitivity and intuition in listening for and responding to desperate pleas for help, and a non-judgmental attitude in dealing with them.

*A list of California's suicide prevention centers is available from the State Department of Public Health, Bureau of Health Education, 2151 Berkeley Way, Berkeley, Calif. 94704.

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